

Department of Health and Human Services  
Aging and Disability Services Division (ADSD)  
**Request for Reimbursement (RFR)**  
**INSTRUCTIONS**

Use one file/workbook per subaward budget period. Use tabs in sequential order from left to right. Do not move or add tabs. If a subaward extends past 15 months, please contact your ADSD Grants and Projects Specialist (GPS) for assistance.

**Fill-in each orange field on the form, including zeros when applicable. When completed correctly, the RFR will have no remaining orange fields. Incomplete RFRs will be returned, unprocessed. Check your RFR for errors before submission.**

**Advance Payments** may only be requested monthly. ADSD must have received and approved a request from the Subrecipient to receive advances. Subrecipients must reconcile an advance payment before additional advance payments will be approved.

**Reimbursements** may be requested monthly or quarterly.

**Top Section:**

On the first tab, enter or verify the Subrecipient Name and Address. Ensure this information matches the Notice of Subaward (NOSA) and information on file with the State Controller's Vendor Services office.

Enter or verify the Subrecipient's EIN (Employer Identification Number) and Vendor # (State of Nevada Vendor Number). Ensure the vendor number is correct and contains an address indicator for payments, if applicable (i.e., T12345678 vs. T12345678A). Contact your GPS\* if the vendor number on your NOSA is incorrect or missing an address indicator letter.

**Financial Report and Request for Reimbursement Section**

Advances: Enter the month and calendar year for which you are requesting an advance payment.

Reimbursements: Enter the month or the months and quarter (i.e., Jan - Mar, Qtr. 3) and calendar year for which you are requesting a reimbursement.

Mark the appropriate checkbox for:

- "Original Request" if this is the first request you've made for the selected month or months/quarter.
- "Revised Request" if you are revising a request already submitted, accepted and processed for payment.
- "Advance" if you've been approved for and are requesting an advance payment.
- "Reimbursement" if you're requesting a monthly or quarterly reimbursement.

**Approved Budget and Columns A-F (gray items below are prefilled or auto-calculated on the RFR):**

**A:** Approved Budget is prefilled and must match the Notice of Subaward (NOSA). These amounts do not reflect carryover.

**B:** Total Prior Requests will calculate based on information entered within the workbook.

**C:** Enter requested funds, not to exceed a total of 1/12 of the total award to ensure funds are available through the fiscal year, unless otherwise directed. The amount of the request is not to be in excess of current needs or in excess of the total approved award. Enter zero if no funds are requested from a specific category. Do not request an amount in excess of each approved budget category without written ADSD approval; a Budget Modification may be required.

Budget category guidance: **Personnel** = Personnel & Fringe Benefits; **Travel/Training** = Staff Travel & Per Diem; **Operating** = Occupancy, Supplies, Public Info, Equipment up to \$4,999 (excluding computer or related equipment); **Equipment** = Equipment over \$5,000 (purchased or leased), any computer or related equipment regardless of cost; **Contractual/Consultant** = Contractual or Consultant Services; **Other** = Other Direct Project Expenses; **Indirect Costs/Admin Expenses** = Approved indirect or administrative expenses, based on percentage in most recent, approved budget.

**D:** Sum of funds requested in the current budget period.

**E:** Balance of the award. If the program had carryover, this amount should match the carryover amount when the last request is submitted.

**F:** Percent of funds requested.

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<b>Additional Financial Reporting - All Award Types</b>
Required match is prefilled.
Enter the matching funds provided during the period. If none, enter zero. If match requirements have been met, enter zero (do not report excess match). Previously reported match will calculate based on information entered into the workbook for previous reports/requests.
<b>Advance Payment Reconciliation</b>
If you're requesting a reimbursement, mark the N/A checkbox. If you checked the Reimbursement checkbox at the top of the form, this checkbox will be marked for you and the cells will be grayed-out.
If you requested advance funds on a prior RFR (or RFF), enter the month(s) you're reconciling and the budget category or categories for which advance funds were used. Multiple items per row are allowed. If funds were advanced for a specific component of a budget only, per ADSD directives, enter a description or name of the service component (i.e., training supplies). Expand the height of the row if needed to ensure all words are visible. Monthly advances must be reconciled once the month is complete and before additional funds are released (i.e., July funds are reconciled in the request submitted by August 15th for September's funds; August funds will be reconciled in the September 15th request for October funds, etc.).
In the <b>Received</b> box, enter the amount of funds <u>advanced</u> based on the categories or components listed.
In the <b>Expended</b> box, enter the amount of advance funds <u>spent</u> based on the categories or components listed. Do not show excess funds spent; only account for the funds advanced by ADSD.
Total funds advanced and expended will calculate in the remaining columns. The Balance is your Cash on Hand. Subrecipients may not retain more than one months' worth of cash on hand.
<b>SUBMITTAL</b>
Enter signer's title and date the form. Sign form before submitting. Electronic/scanned signature is permitted.
<b>Save the completed form on the FTP site and notify your assigned GPS* it is available for download.</b>
Requests for advance payments are due the 15th day before the month of service.
Requests for reimbursements are due the 15th day after the month or quarter of service, depending on a monthly or quarterly request.
<b>Additional Required Form(s) for Back-Up Documentation</b>
<b><i>FIXED-FEE programs are exempt from submitting back-up documentation unless specifically requested by ADSD.</i></b>
<b>Templates for categorical programs are provided online at:</b> <a href="http://adsd.nv.gov/programs/grant/RFRInstructions/">http://adsd.nv.gov/programs/grant/RFRInstructions/</a>
<i>Subrecipients may use their own forms/ledgers if they contain information identical to the associated template.</i>
Required for all requests:
- Transaction Detail List
Required when applicable to a related expense:
- Training Breakdown, Travel Breakdown, Travel Claim, Contract/Consultant Breakdown
<b>ADSD may request additional back-up, such as timesheets, receipts and invoices, to investigate a questionable expense.</b>
<b>* Contact your assigned Grants and Projects Specialist (GPS) if you have questions:</b>
- Alexandra (Alex) Crocket      775-687-0825 <a href="mailto:acrocket@adsd.nv.gov">acrocket@adsd.nv.gov</a>
- Danielle Cooper      702-486-0852 <a href="mailto:dcooper@adsd.nv.gov">dcooper@adsd.nv.gov</a>
- Katrina Fowler      702-486-3518 <a href="mailto:klfowler@adsd.nv.gov">klfowler@adsd.nv.gov</a>
- Laurienne (Laurie) Riley      775-753-1315 <a href="mailto:lriley@adsd.nv.gov">lriley@adsd.nv.gov</a>
- Lisa Torres      775-687-0553 <a href="mailto:ltorres@adsd.nv.gov">ltorres@adsd.nv.gov</a>

## RFR Easy Reference Guide

<b>Department of Health and Human Services</b> <b>Aging and Disability Services (ADSD)</b>		Agency Ref # <b>XXX-XX-XX-XX</b> Budget Account: <b>XXXX</b> GL: <b>XXXX</b> Draw #: <b>1</b> CFDA #: <b>XX.XXX</b>				
<b>Financial Status Report and Request for Reimbursement</b>						
<b>Program Name:</b> ADSD PAC Unit, Grants Management		<b>Subrecipient Name:</b> ABC Agency (this is where the payments go; fiscal management)				
<b>Program Address:</b> 3416 Goni Road, #D-132, Carson City, NV 89706		<b>Subrecipient Address:</b> 123 First Street, No Where, NV 89000				
<b>Subaward Period:</b> XX/XX/XXXX - XX/XX/XXXX (Budget Period)		<b>Subrecipient's:</b> EIN: <b>XX-XXXXXXX</b> Vendor #: <b>XXXXXXXX</b>				
<b>FINANCIAL REPORT AND REQUEST FOR REIMBURSEMENT</b>						
(must be accompanied by expenditure report/back-up)						
<b>Month(s):</b> _____ <b>Calendar Year:</b> _____		<input type="checkbox"/> ORIGINAL REQUEST <input type="checkbox"/> REVISED REQUEST				
		<input type="checkbox"/> ADVANCE <input type="checkbox"/> REIMBURSEMENT				
	A	B	C	D	E	F
Approved Budget Category	Approved Budget	Total Prior Requests	Current Request	Year to Date Total	Budget Balance	Percent Requested
1 Personnel		\$0.00		\$0.00	\$0.00	-
2 Travel		\$0.00		\$0.00	\$0.00	-
3 Operating		\$0.00		\$0.00	\$0.00	-
4 Equipment		\$0.00		\$0.00	\$0.00	-
5 Contract/Consultant		\$0.00		\$0.00	\$0.00	-
6 Training		\$0.00		\$0.00	\$0.00	-
7 Other		\$0.00		\$0.00	\$0.00	-
8 Indirect Costs/ Admin Expenses		\$0.00		\$0.00	\$0.00	-
<b>Total</b>	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	-
<b>Additional Financial Reporting - All Award Types</b>						
Budget Item	Required Amount	Total Prior Months	Current Amount	Year to Date Total	Budget Balance	Percent Provided
1 Match		\$0.00		\$0.00	\$0.00	-
<input type="checkbox"/> N/A						
<b>Advance Payment Reconciliation</b>						
Budget Categories or Specific Components (Expand rows as needed)	Month:	Total Funds to Date				
	Received	Expended	Funds Advanced	Expended	Balance	Percent Expended
			\$0.00	\$0.00	\$0.00	-
			\$0.00	\$0.00	\$0.00	-
I, a duly authorized signatory for the applicant, certify to the best of my knowledge and belief that this report is true, complete and accurate; that the expenditures, disbursements and cash receipts are for the purposes and objectives set forth in the terms and conditions of the subaward; and that the amount of this request is not in excess of current needs or, cumulatively for the award term, in excess of the total approved subaward. I am aware that any false, fictitious or fraudulent information, or the omission of any material fact, may subject me to criminal, civil or administrative penalties for fraud, false statements, false claims, or otherwise. I verify that the cost allocation and backup documentation attached are correct.						
<b>Authorized Signature</b> _____		<b>Title</b> _____		<b>Date</b> _____		
<b>OFFICE USE ONLY - DEPARTMENT OF HEALTH AND HUMAN SERVICES - OFFICE USE ONLY</b>						
Program contact necessary? ____ Yes ____ No      Contact Person: _____						
Reason for contact: _____						
Scope of Work/approval date: _____ Signed: _____						
Fiscal Review/approval date: _____ Signed: _____						

Pre-filled/Locked
Enter or verify

Ensure you use the correct vendor number and that the Subrecipient Name and Address match the record on file with the Controller's office.

Choose Original if this is the first request you've submitted for this month or quarter, as applicable.

Choose Revised if you previously submitted an RFR and were paid for the month. Do not choose this if you're only making corrections and have not yet been paid.

Choose reimbursement or advance. If choosing advance, you must have submitted justification and received approval.

Enter the Month(s) of the Request and the Calendar Year, not the Fiscal Year. Advances may only be for 1 month.

Enter your request for the month in this column, by approved budget category. Categorical programs must provide requested back-up for reimbursements.

Enter your match provided for this period. Do not exceed 100%.

Only include ADSD funding in this section, not all funds spent. We are only tracking the funds we advanced to you.

This is your Cash on Hand.

Include requested back-up to document expenses for expended advance funds.

You may rename tabs within the workbook to help you keep track of your RFR submissions. Double click the tab to rename, or right click and choose Rename. Do not move or copy tabs as the formulas within the sheets will not calculate properly.

R1
R2
R3
R4
R5
R6
R7
R8